SECTION 9

Post-acute care

Skilled nursing facilities
Home health agencies
Long-term care hospitals
Inpatient rehabilitation facilities

Chart 9-1. The number of post-acute care providers generally continues to grow

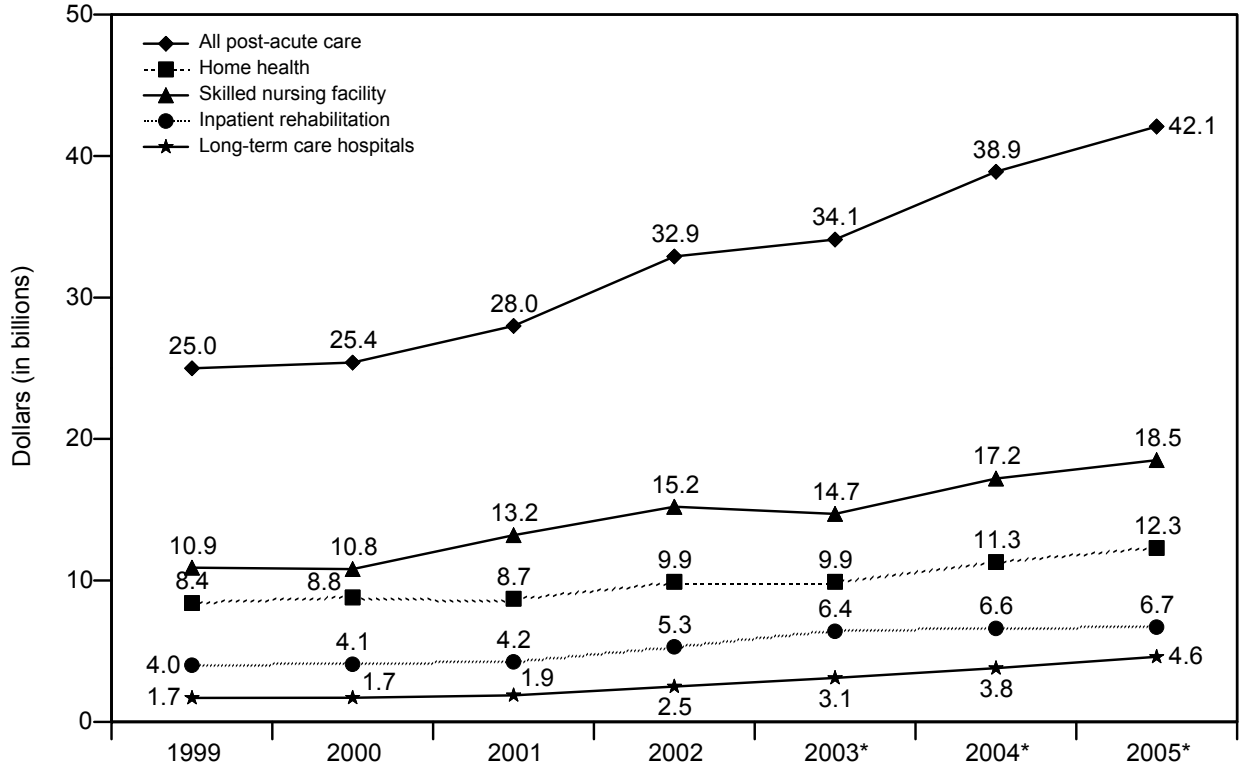
	1996	1998	2000	2002	2004	2005	Percent change 1996–2005
Skilled nursing facilities*	14,548	16,079	16,275	15,089	15,784	15,625	7.4%
Home health agencies	9,808	9,284	7,317	6,888	7,148	8,082	–17.6
Inpatient rehabilitation facilities	1,031	1,078	1,102	1,181	1,206	1,235	19.8
Long-term care hospitals	183	209	240	286	307	375	105.0

Note: *Includes swing bed hospitals.

Source: Online Survey, Certification, and Reporting system from CMS.

- The number of most types of post-acute care providers increased from 1996 to 2005.
- The number of home health agencies reached its peak in 1996 and then dropped. This may be due to many factors, including the interim payment system, increased program integrity scrutiny, and surety bond requirements. The number has begun to increase again in the most recent periods, climbing 17 percent between 2002 and 2005.
- Inpatient rehabilitation facilities increased by 20 percent from 1996 to 2005.
- The number of long-term care hospitals doubled from 1996 to 2005.

Chart 9-2. Spending for post-acute care has risen in each setting, 1999–2005



Note: These numbers are program spending only, and do not include beneficiary copayments.
*Estimated by CMS.

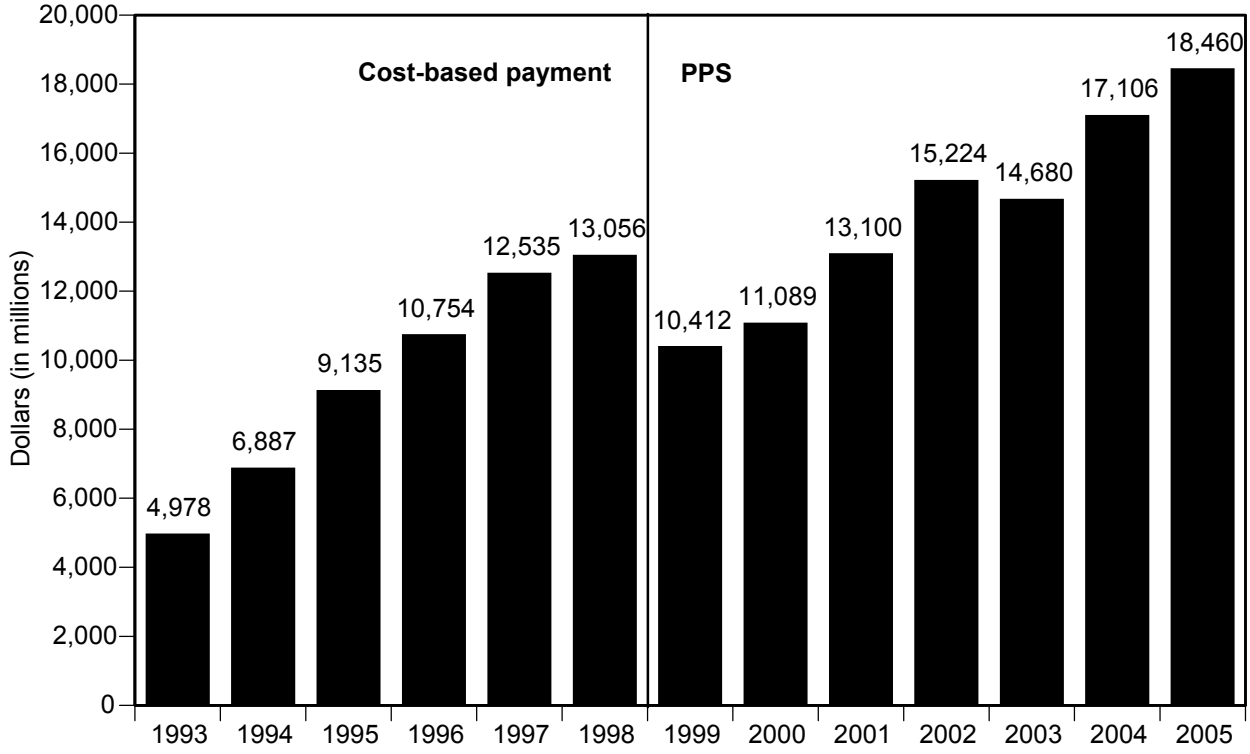
Source: Centers for Medicare & Medicaid Services, Office of the Actuary.

- Medicare has prospective payment systems (PPSs) for the four post-acute care settings. CMS implemented these PPSs at the following times: skilled nursing facilities, July 1998; home health agencies, October 2000; inpatient rehabilitation facilities, January 2002; and long-term care hospitals, October 2002. Although CMS intended to use these payment systems to control Medicare spending for post-acute care, spending has increased an average of 7 percent per year since 1999.

- From 1999 through 2005, Medicare spending for long-term care hospitals has increased the most—at 18 percent per year. During the same period, spending for both skilled nursing facilities and inpatient rehabilitation facilities increased 9 percent per year, and spending for home health agencies increased 7 percent per year. For 2005, CMS estimated that total spending for post-acute care was $42 billion.

- Post-acute care currently makes up about 13 percent of Medicare's total spending.

Chart 9-3. Medicare spending for SNF services generally has increased but growth has moderated since the PPS was implemented



Note: Skilled nursing facility (SNF), prospective payment system (PPS). Spending is program spending for the calendar year.

Source: CMS, Office of the Actuary, 2006.

- Medicare program spending on skilled nursing facility (SNF) services grew an average of 21 percent per year from 1993 through 1998, when Medicare paid SNFs based on their costs, subject to some limits.

- In 1999, immediately following the implementation of the SNF prospective payment system, Medicare program spending on SNF services fell from $13.1 billion to $10.4 billion.

- Between 2000 and 2005, SNF spending grew at a slower rate than before the prospective payment system (PPS), but still averaged 11 percent per year for the period. Factors contributing to the growth during this period include increases in the use of services and increases in the payment rates over the period. Payment rate changes occurred because of annual updates; market basket forecast error correction; and temporary payment add-ons, some of which expired in fiscal year 2003 and some of which expired in January 2006 (year not shown) when CMS changed the patient classification system.

Chart 9-4. Medicare skilled nursing facility use increased between 1999 and 2003

Year	Number of admissions (thousands)	Number of days (millions)	Days per admission
1999	1,796	42.4	23.6
2000	1,824	43.8	24.0
2001	1,950	47.9	24.6
2002	2,223	54.7	24.6
2003	2,385	59.4	24.9
Average annual increase	7%	9%	1%

Note: Data include facilities in Puerto Rico, Virgin Islands, and "unknown." Data do not include swing bed units.

Source: Skilled nursing facility Medicare Provider Analysis and Review stay records from CMS, Office of Research, Development, and Information.

- The number of Medicare admissions to skilled nursing facilities (SNFs) grew at an average annual rate of 7 percent between 1999 and 2003. Increased SNF use exceeds the rate of growth in the Medicare population; during this same period the average annual increase in the number of Part A enrollees was 1.2 percent.

- The number of SNF admissions increased 7 percent between 2002 and 2003, the most recent years for which we have data. Similarly, the number of SNF days increased 9 percent between 2002 and 2003.

Chart 9-5. Characteristics of skilled nursing facilities, 2003

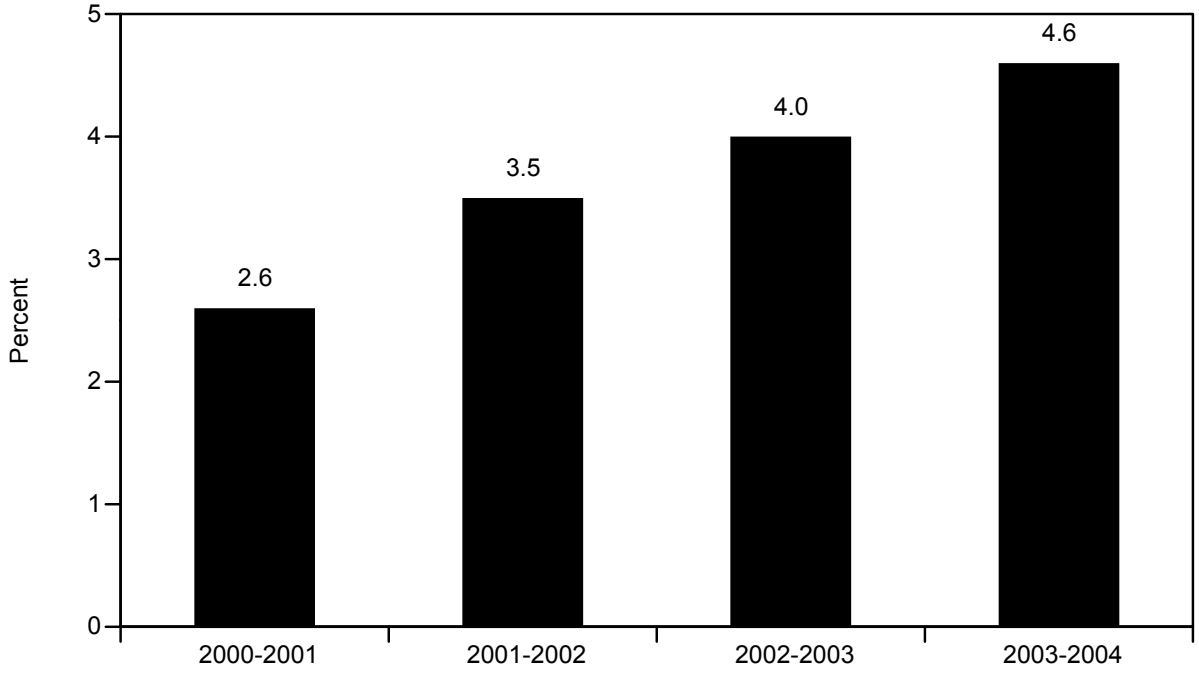
Type of SNF	Facilities	Medicare payments	Medicare-covered stays
Freestanding	90%	90%	83%
Hospital-based	10	10	17
Urban	67	81	78
Rural	33	19	22
Large chain	15	20	17
Not large chain	85	80	83
For profit	67	71	64
Nonprofit	28	26	31
Government	5	3	4

Note: SNF (skilled nursing facility).

Source: MedPAC analysis of the Provider of Services file and 2003 Medicare Provider Analysis and Review file.

- Skilled nursing facility (SNF) services may be provided in freestanding or hospital-based facilities. In 2003, 90 percent of facilities were freestanding, and 83 percent of Medicare-covered SNF stays were in freestanding facilities.
- In 2003, 67 percent of SNFs were for profit. Similarly, a majority of Medicare SNF stays (64 percent) were in for-profit facilities.

Chart 9-6. Medicare costs per day in freestanding SNFs grew at an average annual rate of 3.7 percent between 2000 and 2004



Note: SNF (skilled nursing facility). Medicare per day cost growth was calculated from year to year among the cohort of freestanding SNFs with cost report data in all five years. Cost per day is not adjusted for differences in case mix.

Source: MedPAC analysis of Medicare cost report data from CMS.

- Per-day costs for Medicare beneficiaries in freestanding skilled nursing facilities (SNFs) grew, on average, 3.7 percent annually between 2000 and 2004, with the most recent period seeing a higher rate of growth.
- During this same period, for-profit facilities had lower average annual cost growth (3.5 percent) than nonprofit (4.4 percent) or government facilities (4.5 percent).
- For the least costly SNFs (those at the 25th percentile), average annual per day Medicare cost growth was 1 percent, while for the most costly SNFs (those at the 75th percentile), it was 7.2 percent.

Chart 9-7. Freestanding skilled nursing facility Medicare margin, by facility group, 2004

Facility type	Facilities	Medicare margin
All facilities	11,049	13.5%
Urban	7,606	12.8
Rural	3,432	16.6
Large chain	2,043	18.2
Not large chain	9,006	12.0
For profit	8,374	16.1
Nonprofit	2,304	3.8
Government	371	–1.1

Note: Eleven facilities had missing urban or rural designations.

Source: MedPAC analysis of Medicare cost report and Provider of Service file from CMS.

- Based on 2004 cost report data, we estimate that the 2006 aggregate Medicare margin for freestanding skilled nursing facilities (SNFs) is 9.4 percent. Nonprofit facilities had lower margins (3.8 percent) than for-profit facilities (16.1 percent) in 2004.
- Our projected margin for 2006 is 9.4 percent.

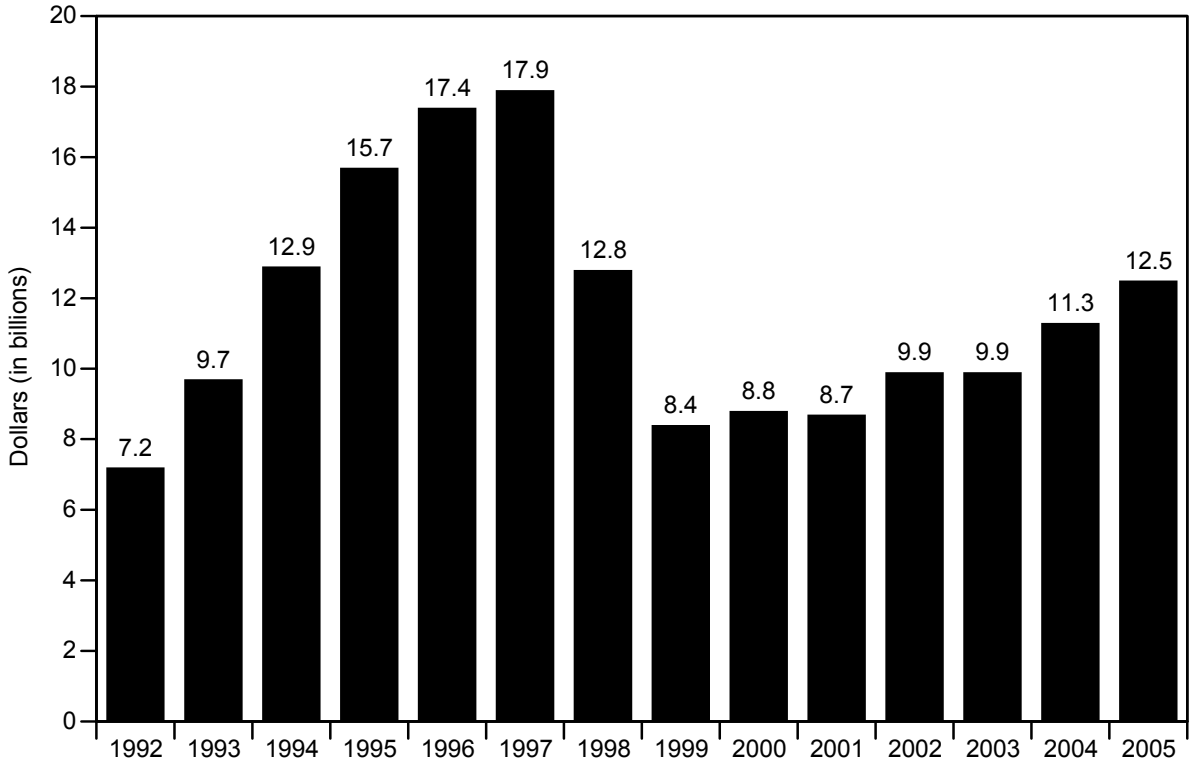
Chart 9-8. The highest percentage of Medicare-covered freestanding SNF days were in "very high" and "high" rehabilitation RUG–III groups in 2004

RUG–III group	Percent of Medicare days
Rehabilitation	**79.7%**
Ultra high, 16–18 ADL	2.3
Ultra high, 9–15 ADL	7.2
Ultra high, 4–8 ADL	1.9
Very high, 16–18 ADL	4.0
Very high, 9–15 ADL	16.8
Very high, 4–8 ADL	5.5
High, 13–18 ADL	14.7
High, 8–12 ADL	10.9
High, 4–7 ADL	3.9
Medium, 15–18 ADL	4.3
Medium, 8–14 ADL	6.0
Medium, 4–7 ADL	2.1
Low, 14–18 ADL	0.1
Low, 4–13 ADL	0.2
Extensive services	**6.5**
7–18 ADL, 4–5 services	2.9
7–18 ADL, 2–3 services	3.4
7–18 ADL, 0–1 services	0.2
Special care	**5.4**
17–18 ADL	1.3
15–16 ADL	1.7
7–14 ADL	2.4
Clinically complex	**6.0**
17–18 ADL, depression	0.2
17–18 ADL, no depression	0.6
12–16 ADL, depression	0.6
12–16 ADL, no depression	1.9
4–11 ADL, depression	0.7
4–11 ADL, no depression	2.0
Nonskilled RUGs	**2.2**
Unknown RUG	0.2

Note: SNF (skilled nursing facility), RUG–III (resource utilization group, version III), ADL (activity of daily living). Total percent may not add to 100 due to rounding. ADLs are expressed in terms of an index. The higher the index, the greater the patient's limitation on activities of daily living. "Services" is a count of the services or conditions that qualify a beneficiary for the extensive services category. The greater the number of services, the greater the anticipated resource use within the extensive services category.

Source: MedPAC analysis of Medicare cost report data from CMS.

Chart 9-9. Spending for home health care, 1992–2005



Note: In 2004, the payment system changed from fiscal year to calendar year.

Source: CMS, Office of the Actuary, 2006.

- Medicare home health care spending grew at an average annual rate of 20 percent from 1992 to 1997. During that period, the payment system was cost based. Eligibility had been loosened just before this period and enforcing the program's standards became more difficult.
- Spending began to fall in 1997, concurrent with the introduction of the interim payment system (IPS) based upon costs with limits, tighter eligibility, and increased scrutiny from the Office of Inspector General.
- In 2000, the prospective payment system replaced the IPS. At the same time, eligibility for the benefit was broadened slightly. Enforcement of the Medicare program's integrity standards continues at the regional home health intermediaries and survey and certification units.
- Since 2001, the number of users, the number of episodes, and the amount of spending have increased.

Chart 9-10. Medicare home health care use, 1992–2003

Year	People served	Visits	
	Number (thousands)	Number (millions)	Per person served
1992	2,506	132	53
1993	2,874	164	57
1994	3,179	209	66
1995	3,469	249	72
1996	3,600	265	74
1997	3,558	258	73
1998	3,062	155	51
1999	2,720	113	42
2000	2,461	91	37
2001	2,403	71	31
2002	2,544	73	31
2003	2,681	75	31

Source: CMS, Office of the Actuary, May 2005.

- In the early 1990s, the rapid growth in home health use was a concern to policymakers. Between 1992 and 1996, the number of beneficiaries using home health care increased by more than one million. The total volume of home health was expanding rapidly as the number of visits per user increased along with the number of users.

- In the mid-1990s, the Congress required home health agencies to begin the transition to a prospective payment system, CMS clarified the standards of eligibility for the home health benefit, and the Office of Inspector General increased its scrutiny of home health. Between 1997 and 2000, the number of users fell by one million.

Chart 9-11. The home health product changed after the prospective payment system started

	1997	2002
Average visits per episode	36	19
Average minutes per episode	1,500	940
Percent therapy visits	9%	26%

Note: The prospective payment system (PPS) began in October 2000.

Source: Pre-PPS CMS analysis of the National Claims History file; post-PPS MedPAC analysis of 5 percent Standard Analytic File.

- The types and quantity of home health care services that beneficiaries receive are changing. In 1997, before the PPS, the average number of visits per episode was 36. By 2002, that had fallen to 19 visits. The average length of stay fell from 106 days in 1997 to 56 days in 2002.

- The mix of visits (therapy, aide, or skilled visits as a percent of total visits provided during an episode) has shifted toward therapy (physical therapy, occupational therapy, and speech pathology) and away from home health aide services. The home health payment system rewards the provision of therapy services (physical, occupational, or speech). Meeting the therapy threshold for a payment episode produces substantially higher payments for otherwise similar patients. For example, an episode for a patient with moderate clinical severity and moderate functional limitation would be paid $2,440 (base payment × case weight 1.08) if the episode did not meet the therapy threshold and $4,420 (base payment × case weight 1.95) if the episode did meet the therapy threshold.

- Information about the use of home health services after the PPS can be found on the CMS website, available at http://www.medicare.gov.

Chart 9-12. Aggregate Medicare margins for all freestanding home health agencies remain in double digits, 2004

Agency group	Number of agencies	2004 margin
All agencies	3,979	16.0%
Caseload		
Urban	2,546	15.9
Mixed	985	17.0
Rural	448	11.8
Type of control		
Voluntary	686	12.4
Private	3,047	18.1
Government	246	8.1
Volume group, lowest to highest		
First quintile	843	13.1
Second quintile	781	10.5
Third quintile	794	12.9
Fourth quintile	792	15.9
Fifth quintile	769	17.5

Note: Some freestanding agencies were omitted because of data integrity concerns.

Source: MedPAC analysis of Medicare Cost Report file from CMS.

- In 2004, 80 percent of agencies had positive margins. These estimated margins indicate that Medicare's payments are above the costs of providing services to Medicare beneficiaries, for both rural and urban home health agencies (HHAs).
- Our projected 2006 margin is 14.7 percent.
- These margins are for freestanding HHAs, which composed two-thirds of all HHAs in 2001. Home health agencies are also based in hospitals and other facilities.

Chart 9-13. The top 15 LTC–DRGs in 2004 made up almost two-thirds of LTCH discharges

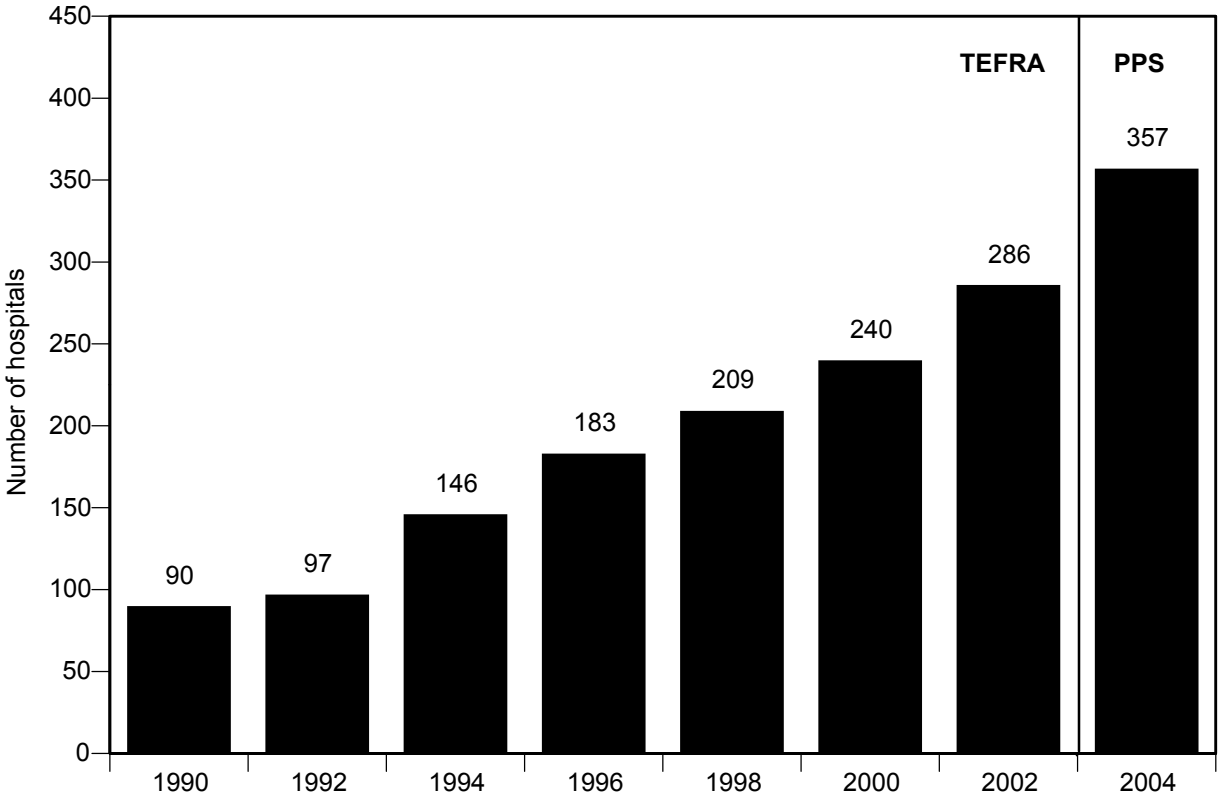
LTC–DRG	Description	Discharges	Percentage
475	Respiratory system diagnosis with ventilator support	13,007	10.6%
249	Aftercare, musculoskeletal system and connective tissue	6,212	5.1
12	Degenerative nervous system disorders	5,802	4.7
271	Skin ulcers	5,594	4.6
462	Rehabilitation	5,072	4.1
88	Chronic obstructive pulmonary disease	4,980	4.1
87	Pulmonary edema and respiratory	4,960	4.1
89	Simple pneumonia and pleurisy with CC	4,826	3.9
466	Aftercare without history of malignancy as secondary diagnoses	4,497	3.7
79	Respiratory infections and inflammations with CC	4,449	3.6
416	Septicemia	4,144	3.4
263	Skin graft and/or debridement for skin ulcer with CCs	3,739	3.1
127	Heart failure and shock	3,699	3.0
316	Renal failure	2,360	1.9
430	Psychoses	2,355	1.9
	15 LTC–DRGs	75,696	61.9
	Total discharges	122,320	100.0

Note: LTC–DRG (long-term care diagnosis related group), LTCH (long-term care hospital), CC (complication or comorbidity).

Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS.

- Long-term care hospitals (LTCHs) treat beneficiaries with diverse diagnoses. Five of the top 15 diagnoses in LTCHs are related to respiratory conditions.
- The most frequent diagnosis for LTCHs is for patients on ventilator support. These beneficiaries make up almost 11 percent of all Medicare LTCH patients.

Chart 9-14. The number of long-term care hospitals has grown rapidly since 1990



Note: TEFRA (Tax Equity and Fiscal Responsibility Act of 1982), PPS (prospective payment system).

Source: MedPAC analysis of Provider of Service file from CMS.

- The number of long-term care hospitals (LTCHs) quadrupled between 1990 and 2004.
- The number of LTCHs increased 10 percent annually during this period.

Chart 9-15. Volume of cases and Medicare spending increased under the LTCH prospective payment system

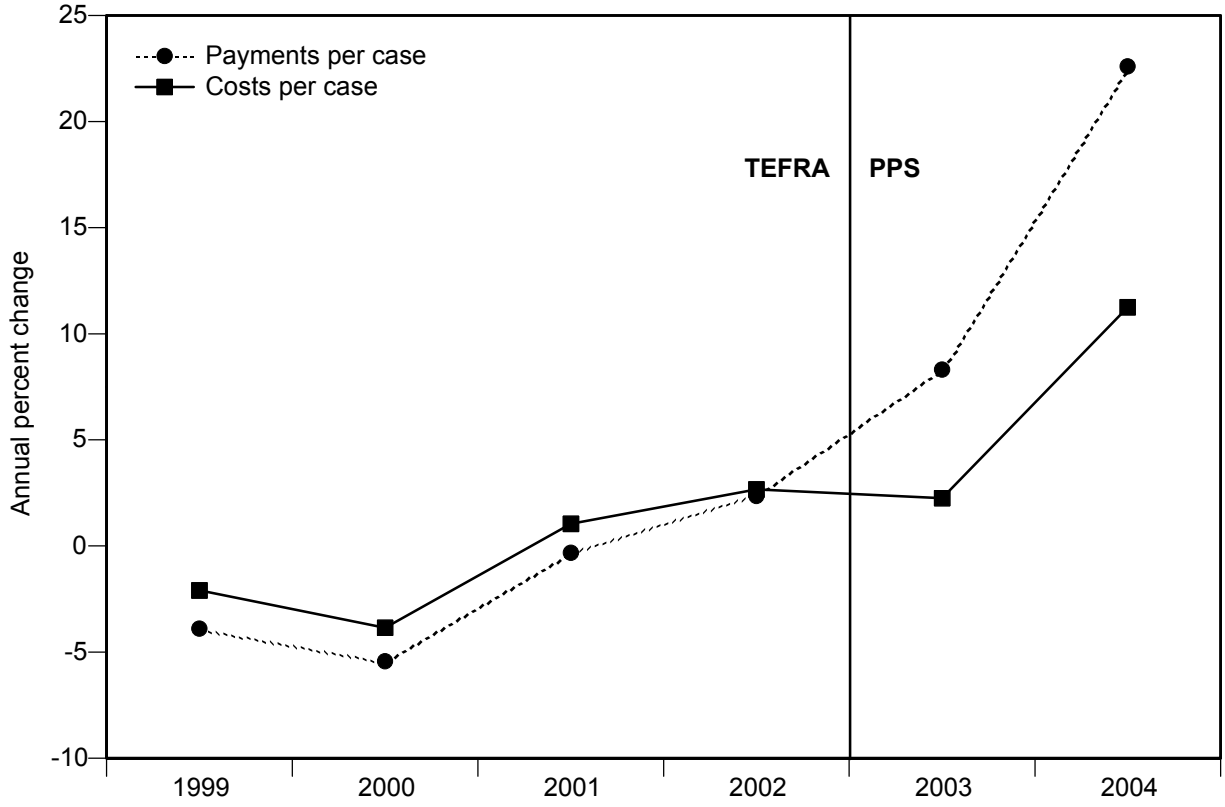
	TEFRA	PPS		Average annual change
	2001	2003	2004	2001–2004
Number of cases	86,049	110,509	122,320	12%
Medicare spending	$1.7 billion	$2.4 billion	$3.3 billion	25
Payment per case	$22,452	$25,076	$30,180	10
Length of stay (in days)	32.1	29.2	28.7	–4

Note: LTCH (long-term care hospital), TEFRA (Tax Equity and Fiscal Responsibility Act of 1982), PPS (prospective payment system).

Source: MedPAC analysis of MedPAR data from CMS.

- The number of beneficiaries discharged from long-term care hospitals (LTCHs) increased 12 percent annually from 2001 to 2004.
- From 2001 to 2004, Medicare spending for long-term care hospitals increased 25 percent per year. In the last year alone, Medicare spending for these facilities increased 38 percent.
- From 2001 to 2004, Medicare's payment per case increased 10 percent annually while length of stay, usually positively associated with costs per case, decreased 4 percent.

Chart 9-16. Comparison of changes in LTCHs' Medicare payments and costs per case, 1999–2004



Note: LTCH (long-term care hospital), TEFRA (Tax Equity and Fiscal Responsibility Act of 1982), PPS (prospective payment system). Data are from consistent two-year cohorts of LTCHs.

Source: MedPAC analysis of cost reports from CMS.

- Under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) and before the prospective payment system (PPS) was implemented in fiscal year 2003, long-term care hospitals' (LTCHs') Medicare per case costs and payments increased at similar rates. Under PPS, LTCHs' Medicare per case payments have increased much faster than their per case costs.

- These similarities and differences are reflected in LTCHs' Medicare margins, shown in Chart 9-17.

Chart 9-17. Long-term care hospitals' PPS Medicare margin, by group, 2003–2004

LTCH group	2003	2004
All LTCHs	5.4%	9.0%
Urban	5.5	9.0
Rural	0.8	8.6
Freestanding	5.2	8.7
HWHs	5.8	9.6
Nonprofit	1.6	6.0
For profit	6.7	10.3
Government	–1.9	–2.8

Note: LTCH (long-term care hospital), PPS (prospective payment system), HWH (hospital within hospital).

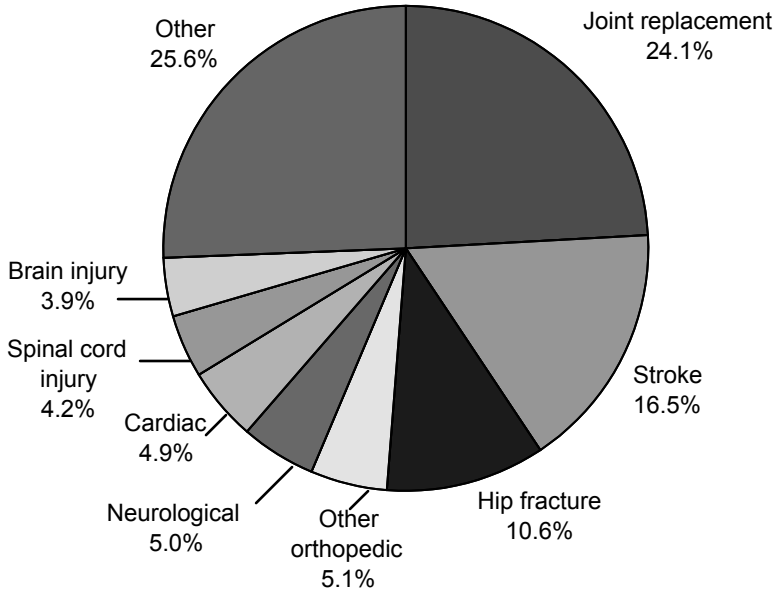
Source: MedPAC analysis of cost reports from CMS.

- Under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) and before long-term care hospitals' (LTCHs') prospective payment system (PPS) was implemented, these facilities' Medicare margins were close to zero, ranging from –1.7 to 0.4 percent. Under PPS, margins have increased rapidly, from 5.4 percent in 2003 to 9.0 percent in 2004.

- In 2004, urban, rural, freestanding, and hospital within hospital (HWH) LTCHs had similar Medicare margins—9.0, 8.6, 8.7, and 9.6 percent, respectively. There is greater variation in Medicare margins by ownership, with nonprofit LTCHs at 6 percent and for-profit LTCHs at 10.3 percent.

- Our projection of the 2006 margin is 7.8 percent.

Chart 9-18. Distribution of most common types of cases in inpatient rehabilitation facilities, 2004



Note: Other includes conditions such as amputation, pain syndrome, and pulmonary.

Source: MedPAC analysis of Inpatient Rehabilitation Facility–Patient Assessment Instrument data from CMS.

- In 2004, the most frequent diagnosis for Medicare patients in inpatient rehabilitation facilities (IRFs) was joint replacement, representing 24.1 percent of cases, a smaller share of IRF cases than in 1996.
- Stroke was the second most frequent diagnosis in 2004, at 16.5 percent of cases. In 1996, stroke made up 19.6 percent of IRF cases.

Chart 9-19. The number of all types of inpatient rehabilitation facilities has grown

Type of IRF	TEFRA 2000	TEFRA 2001	PPS 2002	PPS 2003	PPS 2004	Change 2000–2001	Annual Change 2002–2004	Annual Change 2000–2004
All IRFs	1,117	1,157	1,188	1,211	1,227	4%	2%	2%
Urban	950	971	988	1,001	1,009	2	1	2
Rural	167	186	200	210	218	11	4	7
Freestanding	195	214	215	215	217	10	0	3
Hospital-based	922	943	973	996	1,010	2	2	2
Nonprofit	731	733	755	765	772	0	1	1
For profit	240	271	277	290	294	13	3	5
Government	146	153	156	156	161	5	2	2

Note: IRF (inpatient rehabilitation facility), TEFRA (Tax Equity and Fiscal Responsibility Act of 1982), PPS (prospective payment system).

Source: MedPAC analysis of Provider of Service information from CMS.

- Between 2000 and 2004, the number of inpatient rehabilitation facilities (IRFs) increased 2 percent per year, slightly faster than Medicare beneficiaries.
- Rural IRFs increased the fastest during this period, at 7 percent annually, while nonprofit IRFs increased the slowest, at 1 percent annually.

Chart 9-20. Volume of care and Medicare spending increased under the IRF prospective payment system

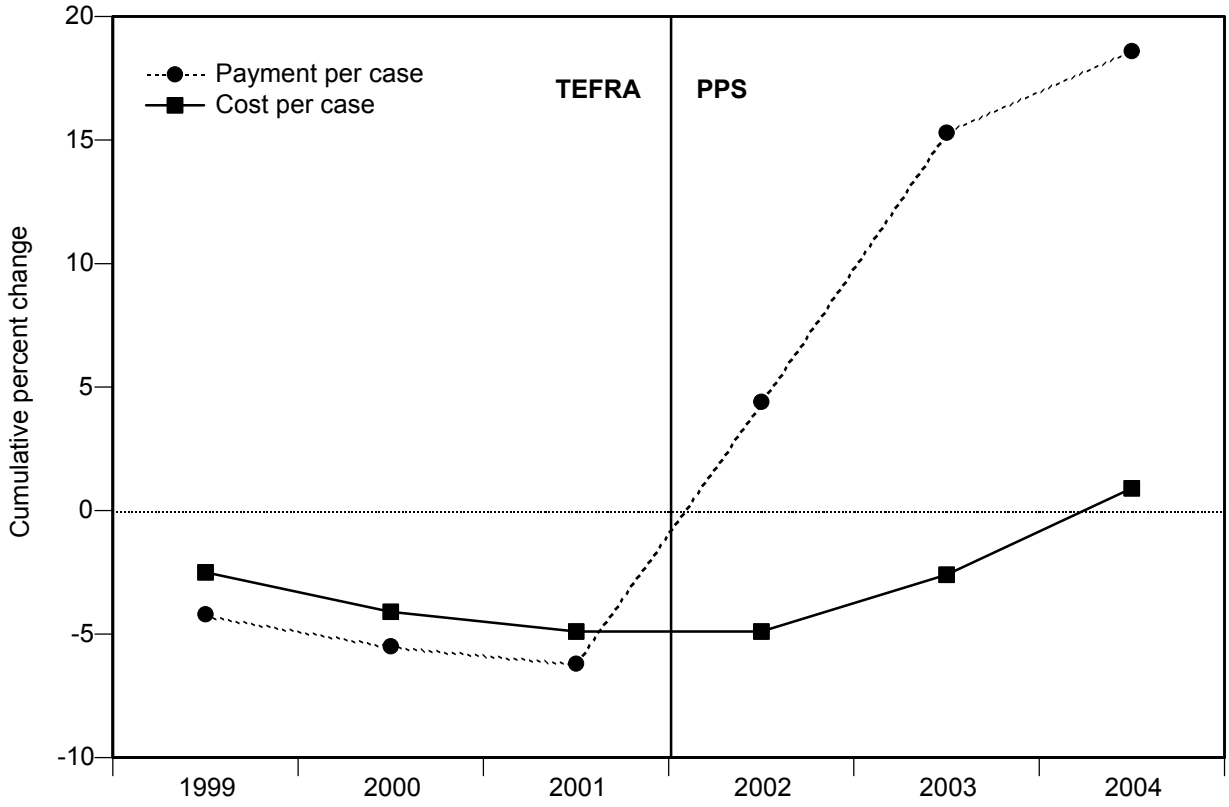
	TEFRA			PPS		
	2000	2001	Change 2000–2001	2002	2004	Average annual change 2002–2004
Number of cases	384,207	415,579	8%	438,631	496,695	6%
Medicare spending	$3.6 billion	$3.7 billion	3	$4.5 billion	$6.0 billion	15
Payment per case	$10,312	$9,982	–3	$11,152	$13,275	9
Length of stay (in days)	14.6	14.0	–4	13.3	12.7	–2

Note: IRF (inpatient rehabilitation facility), TEFRA (Tax Equity and Fiscal Responsibility Act of 1982), PPS (prospective payment system).

Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS.

- The number of Medicare beneficiaries discharged from inpatient rehabilitation facilities (IRFs) increased at a somewhat slower pace under the prospective payment system (PPS), at 6 percent per year, compared with an increase of 8 percent per year under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) during 2000 and 2001.
- Medicare spending increased at a much faster pace under the PPS, at 15 percent per year, compared with 3 percent per year under TEFRA during 2000 and 2001.
- Under PPS from 2002 to 2004, payment per case increased 9 percent per year, while length of stay, usually related to cost per case, decreased 2 percent per year.

Chart 9-21. IRFs' Medicare payments have risen faster than their costs, post-PPS



Note: IRF (inpatient rehabilitation facility), TEFRA (Tax Equity and Fiscal Responsibility Act of 1982), PPS (prospective payment system). Data are from consistent two-year cohorts of IRFs.

Source: MedPAC analysis of cost report data from CMS.

- Under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) and before the prospective payment system (PPS) was implemented in 2002, inpatient rehabilitation facilities' (IRFs') Medicare per case costs and payments increased at similar rates. Under PPS, IRFs' Medicare per case payments have increased much faster than their per case costs.

- These similarities and differences are reflected in IRFs' Medicare margins, shown in Chart 9-22.

Chart 9-22. Inpatient rehabilitation facilities' PPS Medicare margins, by group, 2002–2004

IRF group	2002	2003	2004
All IRFs	11.1%	17.7%	16.3%
Urban	11.7	18.4	16.9
Rural	4.6	10.3	10.6
Freestanding	18.2	23.0	24.2
Hospital-based	6.7	14.6	12.0
Nonprofit	6.7	14.3	12.6
For profit	19.3	24.2	24.4
Government	1.0	9.5	8.6

Note: IRF (inpatient rehabilitation facility), PPS (prospective payment system).

Source: MedPAC analysis of cost report data from CMS.

- Under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) and before the prospective payment system (PPS) was implemented, these facilities' Medicare margins ranged from 1.1 percent to 2.9 percent. Under PPS, margins have increased rapidly, rising to 16.3 percent in 2004.

- In 2004, freestanding inpatient rehabilitation facilities (IRFs) have an aggregate margin that is twice that of hospital-based IRFs. Similarly, the aggregate margin of for-profit IRFs is almost double that of nonprofit IRFs.

- Our projection of the 2006 margin is 9.2 percent. In making this projection, we assumed that facilities will reduce patient volume by 25 percent in response to changes in the criteria for IRFs. Under less conservative assumptions, the Medicare margin could be 3 percentage points higher. With more conservative assumptions, the margin would be 2 percentage points lower.

Web links. Post-acute care

- Chapter 4 of MedPAC's March 2006 Report to the Congress and Chapter 5 of MedPAC's June 2005 Report to the Congress provide information on post-acute care.

  http://www.medpac.gov/publications/congressional_reports/Mar06_Ch04.pdf
  http://www.medpac.gov/publications/congressional_reports/June05_Ch5.pdf

Skilled nursing facilities

- Chapter 4A of MedPAC's March 2006 Report to the Congress, Chapter 2C of MedPAC's March 2005 Report to the Congress, and Chapter 3C of MedPAC's March 2004 Report to the Congress provide information on Medicare margins for skilled nursing facilities.

  http://www.medpac.gov/publications/congressional_reports/Mar06_Ch04A.pdf
  http://www.medpac.gov/publications/congressional_reports/Mar05_Ch02C.pdf
  http://www.medpac.gov/publications/congressional_reports/Mar04_Ch3C.pdf

- The official Medicare website provides information on the prospective payment system and other related issues.

  http://www.cms.hhs.gov/snfpps/

Home health services

- Chapter 4B of MedPAC's March 2006 Report to the Congress provides information on home health services.

  http://www.medpac.gov/publications/congressional_reports/Mar06_Ch04B.pdf

- The official Medicare website provides information on the quality of home health care, and additional information on new policies, statistics, and research, as well as information on home health spending and use of services.

  http://www.cms.hhs.gov/center/hha.asp

Long-term care hospitals

- Chapter 4C of MedPAC's March 2006 Report to the Congress and Chapter 5 of MedPAC's June 2004 Report to the Congress provide information on long-term care hospitals.

  http://www.medpac.gov/publications/congressional_reports/Mar06_ch04c.pdf
  http://www.medpac.gov/publications/congressional_reports/June04_ch5.pdf

- CMS also provides information on long-term care hospitals, including the long-term care hospital prospective payment system.

  http://www.cms.hhs.gov/longtermcarehospitalpps/

Inpatient rehabilitation facilities

- Chapter 4D of MedPAC's March 2006 Report to the Congress provides information on inpatient rehabilitation facilities.

  http://www.medpac.gov/publications/congressional_reports/Mar06_Ch04D.pdf

- CMS provides information on the inpatient rehabilitation facility prospective payment system.

  http://www.cms.hhs.gov/InpatientRehabFacPPS